

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1208
168
Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3407 Wayne Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 55 Yrs. (Specify whether years, months or days)
In this community 55 Yrs.

3. (a) PRINT FULL NAME Dr. Chas. Phillip Becker

3. (b) If veteran, name war No. 3. (c) Social Security No. NO

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maude L. Becker 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Feb. 15 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Springfield Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Dentist

11. Industry or business

MOTHER FATHER { 12. Name Wm. Becker
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mary E. Hyatt
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Maude E. Becker
(b) Address 3407 Wayne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-41 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Eylar Funeral Home
(b) Address 1800 Linwood Blvd. K.C. Mo.

19. (a) Jan 13 1941 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3407 Wayne Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1941 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from 12/28/40 to 1/10/41, 19____; that I last saw him alive on 1/10/41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Due to hypertension
Due to Alcohol

Other conditions suspected coronary thrombosis
(Include pregnancy within 9 months of death)

Major findings: Of operations _____

Of autopsy No.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury h

23. Signature R. L. Claffey (M.D. or other) Address 1103 Grand Date signed 1/4/41

Prof. Bailey

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Chas W. Tielke

Licensed Embalmer No. _____

2644

P. O. Address _____

1800 Pine

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.